Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LISA PERSYN MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name
FEDERATED MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-11-2410-01

MFDR Date Received
MARCH 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay full amount due for services rendered even after a request for reconsideration was submitted."

Amount in Dispute: $355.59

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request for Medical Dispute Resolution involves a disputed amount for EMG/NCV testing ordered by a Division selected designated doctor. The service is not in dispute; however, the amount billed was reduced and reimbursed based on the Texas Medical Fee Guideline. The Carrier stands by its reimbursement as correct. Please note no PPO reductions were taken as part of this bill review."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2011	CPT Code 99203	$3.26	$0.00
	CPT Code 95861 (X1)	$2.15	$0.00
	CPT Code 95903 (X4)	$337.69	$333.35
	CPT Code 95904 (X6)	$.42	$0.00
	HCPCS Code A4566	$9.07	$0.00
TOTAL		$355.59	$333.35

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 790-This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - W1-Workers compensation state fee schedule adjustment.
   - The provider is requesting reconsideration and payment in full for the above charges. We have reviewed these charges and the payment for each service and charges were paid correctly per TX fee schedule guidelines including the correct conversion factore [sic] and division ratio. There was not a PPO reduction taken and no codes were bundled on the original analysis. The provider may take this matter to medical dispute resolution for further disposition.

Issues

1. Is the requestor entitled to additional reimbursement for CPT codes 99203, 95861, 95903 and 95904?
2. Is the requestor entitled to additional reimbursement for HCPCS code A4566?

Findings

1. The respondent states in the position summary that "the amount billed was reduced and reimbursed based on the Texas Medical Fee Guideline. The Carrier stands by its reimbursement as correct."

   The issue in dispute is whether the requestor is due additional reimbursement for the disputed services.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2011 DWC conversion factor for this service is 54.54.

   The Medicare Conversion Factor is 33.9764

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 78754, which is located in Austin, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Austin, Texas.

   Using the above formula, the Division finds the following:

Code	Calculation for Locality Austin	Maximum Allowable	Carrier Paid	Due
99203	(54.54/33.9764) x $102.03 for 1 Unit	$163.78	$163.78	$0.00
95861	(54.54/33.9764) x $130.48 for 1 Unit	$209.45	$209.45	$0.00
95903	(54.54/33.9764) x $65.02 for 4 Units	$444.46	$111.11	$333.35
95904	(54.54/33.9764) x $48.91 for 6 Units	$507.57	$507.60	$0.00

2. 28 Texas Administrative Code §134.203(d) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

According to the DMEPOS fee schedule, HCPCS code A4556 has a total allowable of $12.74 for Texas. Per 28 Texas Administrative Code §134.203(d), the MAR is $15.92. The respondent paid $15.93. As a result, reimbursement of $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is $333.35.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $333.35 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/10/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.